STATE OF TENNESSEE

HEALTH RELATED BOARDS OFFICE OF INVESTIGATIONS
COMPLAINT INFORMATION AND RELEASE

COMPLAINANT/REPORTER:

Your Name: _____

Address: _____
Street City State Zip

Telephone: (_____) _____ (home) (_____) _____ (work)

SUBJECT OF COMPLAINT/REPORT:

Practitioner's Name: _____
(first) (middle) (last) (other)

Address: _____
Street City State Zip

Telephone: (_____) _____

Profession: _____ (i.e., doctor, dentist, R.N., L.P.N., etc.)

License #: _____

Social Security #: _____

Name of Patient if other than yourself _____

Address: _____
Street City State Zip

Telephone: (_____) _____

Relationship of Complainant to Patient:

( ) Self ( ) Parent ( ) Son/Daughter ( ) Legal Guardian/provide court documents
( ) Spouse ( ) Brother/Sister ( ) Friend ( ) Other _____

NOTE: If other than patient or parent of a minor patient, please provide documentation indicating appointment of Legal Authority/Guardianship.

Nature of Complaint/Report (check all that apply) *

( ) Quality of care
( ) Inappropriate prescribing
( ) Excessive test or treatment
( ) Misdiagnosis of condition
( ) Sexual abuse, harassment or contact
( ) Failure to release patient records
( ) Criminal conviction
( ) Problem other than listed above _____
( ) Substance abuse
( ) Impairment/medical condition
( ) Insurance fraud
( ) Advertising violation
( ) Drug Diversion
( ) Patient abandonment/neglect
( ) Charting irregularities
( ) Unlicensed Practice

Have you attempted to contact the practitioner concerning your complaint?
( ) Yes ( ) No Date: _____

Would you be willing to testify if this matter goes to a formal hearing? ( ) Yes ( ) No

Please list any prior and/or subsequent treating practitioners relative to your complaint (please give full name, address and telephone number).

Is there anyone other than yourself that knows about your complaint and could give us further information?

Witnesses (Please give full name, address and phone number):

Please give full details of your complaint/report; include facts, details, dates, locations, etc. (attach additional sheets if necessary). Please attach copies of medical records, correspondence, contracts, newspaper articles, and any other documents that will help support your complaint.

DID YOU REPORT THIS TO ANYONE IN THE AGENCY? (i.e., office, hospital, nursing home, etc.) _____

IF YES, TO WHOM WAS IT REPORTED? _____

WHEN WAS IT REPORTED? _____

WHAT IS YOUR RELATIONSHIP TO THIS PRACTITIONER? _____

HAS THIS MATTER BEEN REPORTED TO THE POLICE? _____

REPORT OF POSSIBLE VIOLATION

NAME OF REPORTING PERSON: _____

ADDRESS: _____
(STREET) (CITY) (STATE) ZIP E-MAIL

TELEPHONE: _____

FULL NAME OF THE PRACTITIONER: _____

WHERE IS THE PRACTITIONER EMPLOYED? _____

THE PRACTITIONER'S TITLE OR POSITION? _____
WHERE?

DETAILS OF THE COMPLAINT – ATTACH COPIES OF RELEVANT DOCUMENTS IF AVAILABLE (USE ADDITIONAL SHEETS IF NECESSARY):

(GIVE SPECIFICS INCLUDING WHAT HAPPENED, THE DATE, PLACE AND TIME OF OCCURRENCE)

LIST NAMES, ADDRESSES AND TELEPHONE NUMBERS OF OTHER PEOPLE WHO KNOW OF THIS POSSIBLE VIOLATION

I CERTIFY THAT ALL INFORMATION THAT I HAVE PROVIDED HEREIN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____
SIGNATURE

_____
DATE

EMPLOYER'S REPORT OF POSSIBLE VIOLATION

FULL NAME OF THE PRACTITIONER BEING REPORTED _____
PRACTITIONER'S LICENSE NUMBER AND PROFESSION (e.g., MD, RN, LPN) _____ **SOCIAL SECURITY #** _____
LOCATION WHERE OFFENSE OCCURRED _____
DATE OR CUMULATIVE DATES OF OCCURRENCE _____
PRACTITIONER'S POSITION OR TITLE _____
PRACTITIONER'S IMMEDIATE SUPERVISOR _____
CUMULATIVE DATES OF EMPLOYMENT: FROM: _____ **TO:** _____
CURRENT STATUS OF EMPLOYMENT _____ **NAME OF FACILITY ADMINISTRATOR** _____
ADDRESS _____
STREET CITY STATE ZIP
TELEPHONE _____ **FAX** _____ **E-MAIL** _____
PLEASE PROVIDE DIRECT NUMBERS OR EXTENSIONS
NAME OF DIRECTOR OF NURSING (FOR NURSING COMPLAINTS) _____
NAME AND TITLE OF INDIVIDUAL FILING THIS REPORT _____
NATURE OF COMPLAINT/REPORT (CHECK ALL THAT APPLY)*

( ) QUALITY OF CARE
( ) INAPPROPRIATE PRESCRIBING
( ) EXCESSIVE TEST OR TREATMENT
( ) MISDIAGNOSIS OF CONDITION
( ) SEXUAL ABUSE, HARRASSMENT OR CONTACT
( ) CRIMINAL CONVICTION
( ) PROBLEM OTHER THAN LISTED ABOVE _____
( ) SUBSTANCE ABUSE
( ) IMPAIRMENT/MEDICAL CONDITION
( ) INSURANCE FRAUD
( ) DRUG DIVERSION
( )PATIENT ABANDONMENT/NEGLECT
( ) CHARTING IRREGULARITIES
( ) UNLICENSED PRACTICE

PLEASE PROVIDE THE NAME, TITLE AND MAILING ADDRESS OF THE INDIVIDUAL TO WHOM SUBPOENAS SHOULD BE DIRECTED:

_____
_____
WAS A DRUG SCREEN PERFORMED? _____ **TYPE OF SCREEN, (URINE, SERUM, ETC.)** _____
DATE/TIME OF SPECIMEN COLLECTION _____ **WAS CHAIN OF CUSTODY FOLLOWED?** _____
NAME OF TESTING LAB _____
FULL NAME AND TITLE OF THE INDIVIDUAL COLLECTING THE SPECIMEN: _____
LIST THE SPECIFIC SECTION OF THE APPROPRIATE TENNESSEE PRACTICE ACT AND THE TENNESSEE BOARD REGULATIONS THAT YOU BELIEVE HAVE BEEN VIOLATED: _____
_____
IDENTIFY BY TITLE ALL ACCOMPANYING DOCUMENTATION AND IT'S RELEVANCE (PLEASE NOTE BUT DO NOT HIGHLIGHT RELEVANT INDIVIDUAL ENTRIES):

(1) _____
(2) _____
(3) _____
(4) _____
(5) _____
(6) _____
(7) _____
(8) _____
(9) _____
(10) _____
(USE ADDITIONAL SHEETS AS NECESSARY)

PREVIOUS DISCIPLINARY (COUNSELING) ACTIONS:
DATE _____ **NATURE OF THE OFFENSE** _____ **ACTION TAKEN** _____
PREVIOUS DISCIPLINARY (COUNSELING) ACTIONS:
DATE _____ **NATURE OF THE OFFENSE** _____ **ACTION TAKEN** _____
WITNESS: _____
FULL NAME
HOME ADDRESS _____
STREET CITY STATE
TELEPHONE ( ) _____
WITNESS: _____
FULL NAME
HOME ADDRESS _____
STREET CITY STATE
TELEPHONE ( ) _____
WITNESS: _____
FULL NAME
HOME ADDRESS _____
STREET CITY STATE
TELEPHONE ( ) _____
WITNESS: _____
FULL NAME
HOME ADDRESS _____
STREET CITY STATE
TELEPHONE ( ) _____
WITNESS: _____
FULL NAME